No. 00-1471

OCT 31

IN THE

Supreme Court of the United States

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., *et al.*,

Petitioners,

v.

JANIE MILLER, COMMISSIONER OF THE KENTUCKY DEPARTMENT OF INSURANCE,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF OF *AMICI CURIAE* AMERICAN MEDICAL ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION, NATIONAL MEDICAL ASSOCIATION, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AND KENTUCKY MEDICAL ASSOCIATION IN SUPPORT OF RESPONDENT

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QUESTION PRESENTED

Whether this Court should modify its analysis for determining whether state laws "relate to" employee benefit plans under ERISA's preemption provision, 29 U.S.C. § 1144(a).

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INTEREST OF *AMICI CURIAE*

The American Medical Association ("AMA"), American Psychiatric Association ("APA"), National Medical Association ("NMA"), American College of Obstetricians and Gynecologists ("ACOG"), and Kentucky Medical Association ("KMA") submit this brief as *amici curiae* in support of Respondent Janie Miller, Commissioner of the Kentucky Department of Insurance.[1]

The AMA, an Illinois not-for-profit corporation founded in 1847, is the country's largest medical society. Its approximately 260,000 member physicians practice in all fields of medical specialization in every state. The AMA is dedicated to promoting the science and art of medicine and the betterment of public health.

The APA, with approximately 42,000 members, is the country's leading organization of physicians specializing in psychiatry. The APA and its members have a strong interest in ensuring that the practices of health maintenance organizations ("HMOs") not impair patients' ability to receive, and doctors' ability to deliver, proper medical care.

The NMA is the largest and oldest national organization representing African American physicians and health professionals in the United States. Established in 1895, the

1. Pursuant to Rule 37.6, *amici* state that no counsel for a party authored this brief in whole or in part. *Amicus* AMA joins this brief on its own behalf and as a representative of the Litigation Center of the AMA and the State Medical Societies ("Litigation Center"), a coalition of the AMA and private, voluntary, non-profit state medical societies established to present the views of organized medicine in the courts. The Litigation Center made a monetary contribution to the preparation and submission of this brief. Pursuant to Rule 37.3, the parties have consented to the filing of this brief. The parties' letters of consent have been lodged with the Clerk of this Court.

NMA represents more than 25,000 African American physicians and the patients they serve. The NMA is committed to improving the health status and outcomes of minority and disadvantaged people through its membership, professional development, community health education, advocacy, research, and efforts with federal and private agencies and corporations.

The ACOG, with over 43,000 members, is the nation's leading group of professionals providing health care for women. Founded in 1951, the ACOG works in primarily four areas: (1) serving as a strong advocate for quality health care for women; (2) maintaining the highest standards of clinical practice and continuing education for its members; (3) promoting patient education and involvement in medical care; and (4) increasing awareness among its members and the public of the changing issues facing women's health care.

The KMA is an association of almost 7,000 physicians who reside or practice in the State of Kentucky. It was founded in 1851 to promote the science and art of medicine, protect public health, elevate the standards of medical education, and unite the medical profession in Kentucky.

Amici each seek to protect the integrity of the patient-physician relationship in order to provide quality medical care for patients. *Amici* are interested in this matter because approximately forty states have some type of "any willing provider" ("AWP") statute.[2] These statutes regulate the

2. *See, e.g.*, Ala. Code § 27-45-3 (2002) (choice of pharmacy); Ark. Code Ann. § 23-79-114 (2002) ("no person entitled to benefits . . . shall be denied his or her freedom of choice of any practitioner . . . by any insurer."); Colo. Rev. Stat. § 10-16-107 ("any willing provider"); Ga. Code Ann. § 33-21-29 (2002) (enrollee allowed to name one or more out-of-network providers); Ind. Code Ann.

(Cont'd)

relationship between these professionals and managed care organizations ("MCOs"). In addition, the Court's preemption analysis may impact other state laws that govern the relationship between MCOs and physicians.[3]

States have traditionally regulated both the clinical and the economic aspects of the provision of health care, which are often "inextricably mixed." *Pegram v. Herdrich*, 530 U.S. 211, 229 (2000). The Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"), on the other hand, does not regulate health care, including the practice of medicine. As a result, a regulatory void is created to any extent that ERISA is held to preempt state regulation in this area. Where and how to draw the line between areas of traditional state regulation, like health care, and the

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§ 27-8-11-3 (no hospital, physician, pharmacist willing to meet terms and conditions will be denied right to enter into agreement); Minn. Stat. § 62Q.095 (2001) (expanded network for plans with fewer than 50,000 enrollees shall accept providers that meet credentialing standards, agree to terms of plan's contract, and to comply with protocols); R.I. Gen. Laws § 5-35-21.1 (2001) ("[f]reedom of choice for eye care"); S.D. Codified Laws § 34-1-20 (Michie 2002) (enrollees in HMOs through public health programs have right to choose own physician); Utah Code Ann. § 31A-22-617 (2002) (any licensed provider willing and able to meet terms and conditions of PPO can be designated preferred provider); Wyo. Stat. Ann. § 26-22-503 (Michie 2002) (". . . nor shall any Wyoming provider willing to meet the established terms and conditions be denied the right to enter into any written agreement").

3. *See, e.g.*, Tex. Civ. Prac. & Rem. Code § 88.002(f) (prohibits an MCO from dropping or refusing to renew a provider for advocating medically necessary treatment); *id.*, § 88.002(g) (prohibits an MCO from including indemnification clauses in contracts with providers that would hold it harmless for its own acts); *see also infra* at 8-9 (listing similar Kentucky statutes).

exclusive federal regulation of employee benefit plans has troubled this Court and lower courts almost since ERISA's enactment.

In this case, Petitioners have focused their argument on ERISA's insurance savings provision and assert that the Kentucky statute at issue, Ky. Rev. Stat. Ann § 304.17A-270, is not saved from ERISA § 514(a) preemption because it is not a statute that "regulates insurance." 29 U.S.C. § 1144(b)(2)(A). *Amici* disagree with this position, but, on a more fundamental level, *amici* believe that Petitioners have largely miscast the nature of the inquiry and, in doing so, run the risk of muddying even further the boundary of ERISA's preemptive scope. Avoidance of unnecessary regulatory gaps depends most importantly upon the scope of field preemption under ERISA § 514(a), which generally provides that ERISA supersedes state laws to the extent they "relate to" covered employee benefit plans. In contrast, reliance upon the insurance savings provision of ERISA § 514(b)(2)(A) to preserve state regulatory authority does so only to the extent plans and plan sponsors elect to purchase insurance as the funding mechanism for plan benefits. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 735 n.14 (1985). The consequence of *Metropolitan Life* is to significantly dilute the states' ability to regulate health care and other areas of traditional state concern. *See* U.S. Gen. Accounting Office, Employer-Based Managed Care Plans: ERISA's Effects on Remedies for Benefit Denials and Medical Malpractice 6 (1998) ("approximately 40 percent of insured people are enrolled in self-funded plans, plans that are free from state insurance regulation.").

Amici believe ERISA § 514 should be reexamined to establish properly the line between regulation of health care (and other areas of traditional state regulation) and the exclusively federal regulation of employee benefit plans.

In particular, *amici* propose that the Court refine its analysis of what it means for a state law to "relate to" an employee benefit plan. 29 U.S.C. § 1144(a). *Amici* suggest an analysis that will provide clearer guidance for the lower courts when faced with ERISA § 514(a) preemption issues and properly restrict field preemption to the area of ERISA's regulatory concerns.[4]

SUMMARY OF ARGUMENT

This case demonstrates the importance of a close examination of ERISA's text as well as its underlying structure and objectives when deciding whether a state law "relate[s] to" an employee benefit plan. Congress' goal in enacting ERISA was to provide: (1) disclosure and other safeguards with regard to the establishment, operation, and administration of employee benefit plans; and (2) minimum standards to ensure the equitable character of such plans and their financial soundness. 29 U.S.C. § 1001(a). ERISA's preemption provision, 29 U.S.C. § 1144(a), states that ERISA "shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan." Petitioners, several Kentucky HMOs and their trade organization, along with their *amici*, have argued that ERISA § 514(a) preempts Kentucky's AWP statute, Ky. Rev. Stat. Ann § 304.17A-270, because the statute does not "regulate[] insurance" within the meaning of ERISA § 514(b)(2)(A), 29 U.S.C.

4. A Respondent and its supporting *amicus* are not limited to the "question presented" by the Petitioner, but rather may properly argue any ground to support the judgment that was raised in the court below. See Robert L. Stern, Eugene Gressman, Stephen M. Shapiro & Kenneth S. Geller, Supreme Court Practice 422 (8th ed. 2002). In this case, Respondent raised and the court below decided the "relate to" issue under ERISA § 514(a). *See Kentucky Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352, 357-64 (6th Cir. 2000). The *amici* are informed that Respondent will also argue the § 514(a) "relate to" issue in this Court.

§ 1144(b)(2)(A). In doing so, Petitioners largely have leapfrogged over the antecedent question of whether the Kentucky statute even "relate[s] to" employee benefit plans. *Id.*, § 1144(a).

Kentucky's AWP statute does not "relate to" employee benefit plans. Rather, it is one of myriad state laws that regulate health care. This Court has repeatedly indicated that, in the absence of a clear expression of congressional intent, federal statutes should not displace traditional state regulation of health care. ERISA contains no such clear expression of congressional intent. In fact, "[n]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *New York State Conf. Of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995).

An examination of ERISA reveals that it regulates employee benefit plans and the relationships those plans have with certain other entities, such as plan sponsors, plan fiduciaries, and plan participants and beneficiaries. ERISA § 514's "relate to" preemption provision should be construed to be congruent with ERISA's regulatory scope, an analysis that is consistent with general field preemption principles.

As Petitioners themselves stress, the Kentucky statute does not govern either employee benefit plans or the relationships those plans have with other ERISA-regulated entities. Instead, this statute regulates the relationship between physicians (and other health care professionals) and "health insurers" as defined by the Kentucky legislature. The Kentucky statute has, at most, the kind of "indirect economic effect" on employee benefit plans that this Court has held does not give rise to ERISA § 514(a) preemption. *Travelers*, 514 U.S. at 659. In addition to the fact that the Kentucky statute does not "relate to" an employee benefit plan, it also "regulates insurance" within the meaning of ERISA

§ 514(b)(2)(B) and therefore would be saved from ERISA § 514(a) preemption in any event.

For these reasons, *amici* urge this Court to affirm the judgment of the Sixth Circuit and reformulate its interpretation of ERISA § 514(a) preemption. This will fulfill ERISA's regulatory concerns, while better allowing states to continue to regulate other areas of state concern, including health care.

ARGUMENT

I. THE KENTUCKY STATUTE IS NOT PREEMPTED BY ERISA BECAUSE IT DOES NOT "RELATE TO" EMPLOYEE BENEFIT PLANS WITHIN THE MEANING OF ERISA § 514(a).

Petitioners and their *amici* gloss over the important question of whether the Kentucky statute "relate[s] to" employee benefit plans. 29 U.S.C. § 1144(a). *Amici* believe it does not. Instead, the state statute regulates health care — a traditional area of state concern. The Kentucky statute lies far afield from ERISA's regulatory scope and concerns.

A. The Kentucky statute is an economic regulation of health care.

Kentucky's AWP statute provides that "[a] health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships." Ky. Rev. Stat. Ann § 304.17A-270. A "provider" or "health care provider" is defined to include physicians as well as other types of health care practitioners. *Id.*, § 304.17A-005(19).

Petitioners describe the effect of the statute as requiring them "to throw open their closed provider networks to any provider in the geographic area willing to abide by the terms of their network contracts." Pet. Brief at 4. Petitioners assert that:

> Because an HMO's ability to control costs and quality depends in large part on its ability to determine for itself the providers with network access, . . . the unavoidable consequence of the law[] is to drive up the costs of the health care services managed by HMOs and to affect their ability to regulate efficiently the quality of care offered by network providers.

Id. at 4-5. This increase in health care costs provided by HMOs is said ultimately to affect ERISA-governed employee benefit plans because some HMOs "contract[] with ERISA plans to enroll plan beneficiaries as direct subscribers in the HMO[, and some] also make their provider networks available to self-funded employee benefit plans, for which the HMOs provide only administrative services and bear no risk." *Id.* at 3. According to Petitioners, controlling access to their networks is "fundamental to the entire enterprise of managing the quality and costs of health care." *Id.*

As this argument shows, Kentucky's AWP statute is part of Kentucky's regulation of the economic relationships between physicians and other health care professionals on the one hand and HMOs and other insurers on the other. These economic relationships are "inextricably mixed" with the delivery of health care. *Pegram*, 530 U.S. at 229. Consequently, the state extensively regulates these relationships. *See, e.g.*, Ky. Rev. Stat. Ann. § 304.17A-350 (limiting the circumstances under which an insurer can delay payment on a claim to a health care provider); *id.*, § 304.17A-

525 (requiring insurer to establish standards for health care provider participation in a plan); *id.*, § 304.17A-560 (prohibiting insurer from inserting "most-favored-nation" provision in contract with health care provider); *id.*, § 304.17A-702 (establishing time frame in which insurer must pay health care provider's claims); *id.*, § 304.17A-728 (requiring insurer to disclose discounted fees in contract with health care provider and stating that failure to do so violates state's unfair claims settlement practices).

It should be clear that such state regulation of health care is not preempted by ERISA, entirely apart from the insurance savings provision of ERISA § 514(b)(2)(A). This Court has said that "[n]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. at 661. This Court has also held that "hospitals operated by ERISA plans are subject to the same laws as other hospitals." *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 808 (1997). This Court has indicated that preemption of state standards of reasonable medical care and medical malpractice should be avoided. *Pegram*, 530 U.S. at 236-37 (concluding that mixed eligibility and medical treatment decisions are not fiduciary decisions and therefore not within the ambit of ERISA).

In addition, this Court has held that the economic regulation of health care does not "relate to" employee benefit plans within the meaning of ERISA § 514(a), although such regulation may have an indirect, and even direct, economic effect on ERISA plans. *See Travelers*, 514 U.S. at 659 ("indirect economic effect" of hospital bill surcharges does not "relate to" an ERISA plan); *De Buono*, 520 U.S. at 815-16 (tax on hospital run by ERISA plan does not "relate to" plan despite direct impact on plan). Like the state laws in

Travelers and *De Buono*, the Kentucky statute is another health care regulation that may "increase[] the cost of providing benefits to covered employees [and so] will have some effect on the administration of ERISA plans." *De Buono*, 520 U.S. at 816. However, that effect by itself "simply cannot mean" that the statute "relate[s] to" ERISA plans and therefore is preempted by ERISA § 514(a). *Id.* As this Court recently stated, "although the added compliance cost to the HMO may ultimately be passed on to the ERISA plan, . . . such 'indirect economic effects,' are not enough to preempt state regulation even outside of the insurance context." *Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151, 2167 n.11 (2002) (quoting *Travelers*, 514 U.S. at 659).

Notwithstanding this Court's statements and holdings in these cases, the court below held that the Kentucky statute does "relate to" employee benefit plans (and therefore would be preempted but for the insurance savings provision). This and similar holdings in the lower courts indicate the need for more clarity concerning the scope of "relate to" preemption under ERISA § 514(a). Preemption under § 514(a) operates as field preemption, with the states ousted of all regulatory authority over matters that "relate to" ERISA plans. Section 514(a) preemption therefore creates the potential for regulatory voids. This is not a problem where the regulatory gap was intended by Congress, such as leaving unregulated employer decisions whether to offer benefit plans, what types and levels of benefits to offer, and whether to purchase an MCO product or other insurance coverage to fund the benefits. It is a problem in areas where there is no indication that Congress intended to preclude the states from regulating, such as health care and the practice of medicine. There is a strong need, therefore, to better define the scope of "relate to" preemption and thereby specify the boundary of the preempted field.

This Court itself has expressed concern that the boundaries of ERISA § 514(a) "relate to" preemption are difficult to discern. *See, e.g., Travelers*, 514 U.S. at 655 ("we have to recognize that our prior attempt to construe the phrase 'relate to' does not give us much help drawing the line here.") (internal citation omitted); *De Buono*, 520 U.S. at 813 (same). It has also grappled repeatedly with how to derive substance from the limiting phrase "relate to" in a way that sets meaningful boundaries to the scope of § 514(a). As this Court stated in *Travelers*, "[if] 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course, for 'really, universally, relations stop nowhere.'" *Travelers*, 514 U.S. at 655 (internal citation omitted); *see also California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 329 (1997)

> if ERISA were concerned with any state action — such as medical-care quality standards or hospital workplace regulations — that increased costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we could scarcely see the end of ERISA's pre-emptive reach, and the words "relate to" would limit nothing.

Amici therefore propose a mode of analysis under ERISA § 514(a)'s preemption provision that more clearly separates the area occupied by ERISA's exclusive federal regulation from other areas of state regulation, such as health care and the practice of medicine. The basics of this approach may be simply stated. First, the scope of ERISA's regulatory domain should be identified based upon the structure and content of ERISA as a whole. Second, the scope of field preemption under ERISA § 514(a) should be held to be congruent with ERISA's regulatory domain. This approach is consistent with and gives meaningful content to § 514(a)'s statutory language. It also preempts state laws in areas where it makes

substantive sense to do so. At the same time, this approach respects "the separate spheres of governmental authority preserved in our federalist system," *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 19 (1987), and avoids the "unsettling" possibility that ERISA § 514(a) "results in the pre-emption of traditionally state-regulated substantive law in those areas where ERISA has nothing to say." *Dillingham*, 519 U.S. at 330.[5]

B. ERISA's domain is the employee benefit plan and those relationships between the plan and other entities and individuals that ERISA regulates.

ERISA's core focus is upon the establishment, content and operation of the "employee benefit plan" itself. In general, an employee benefit plan is the formal mechanism through which a plan sponsor (usually the employer) provides benefits to employees and related plan beneficiaries. This Court has said that ERISA's definitions of "employee welfare benefit plan" and "employee benefit plan" in 29 U.S.C. §§ 1002(1)(A) and 1002(3) are "ultimately circular." *Pegram*, 530 U.S. at 222. Nevertheless, these plans are fully described by the statute's legal requirements for a properly established plan.

In terms of the criteria applicable to both welfare benefit and pension plans, an ERISA plan must be "established and maintained pursuant to a written instrument." 29 U.S.C. § 1102(a)(1). That written instrument must identify at least one named fiduciary who has authority to control and manage the operation and administration of the plan, including the

5. As discussed below, the analysis advocated here concerns field preemption under ERISA § 514(a)'s "relate to" provision. It does not address or alter express or implied conflict preemption under ERISA, a matter this Court has held should be separately addressed.

responsibility to deny benefit claims. *Id.*, § 1102(a)(1), § 1133(2). Every employee benefit plan must also:

> (1) provide a procedure for establishing and carrying out a funding policy and method consistent with the objectives of the plan and the requirements of [ERISA], (2) describe any procedure under the plan for the allocation of responsibilities for the operation and administration of the plan (including any procedure described in section 1105(c)(1) of [ERISA]), (3) provide a procedure for amending such plan, and for identifying the persons who have authority to amend the plan, and (4) specify the basis on which payments are made to and from the plan.

29 U.S.C. § 1102(b).

An ERISA plan must provide a summary plan description ("SPD") to plan participants and beneficiaries, written in a manner calculated to be understood by the average participant, which contains a detailed list of information. *Id.*, § 1122; *see also* 29 C.F.R. § 2520.102-3 (listing plan contents that must be described in the SPD). An employee benefit plan must afford its plan beneficiaries some mechanism for internal review of a denial of benefits. *Id.*, § 1133(2). Moreover, an employee benefits plan is a distinct legal entity that "may sue or be sued" for plan benefits and other purposes. *Id.*, § 1132(d)(1).[6]

6. ERISA, of course, goes on to extensively regulate the administration of employee benefit plans by imposing, *inter alia*, reporting and disclosure requirements, 29 U.S.C. §§ 1021-31, participation and vesting requirements (except for employee welfare benefit plans), *id.*, §§ 1051-61, funding obligations (except for employee welfare benefit plans), *id.*, §§ 1081-86, administrative provisions and civil and criminal enforcement provisions, *id.*, §§ 1131-45, and various additional standards for group health plans, *id.*, §§ 1161-91. This is the heart of what ERISA does.

An important point illustrated by these statutory criteria is that an ERISA "employee benefit plan" must be distinguished from products offered by HMOs and other MCOs. These products are not ERISA plans but instead are commercial products that an MCO may sell to ERISA plans (as well as to other entities and individuals). These MCO products sometimes use the term "plan" or "health plan" in their name, but they are not ERISA plans. Rather, when purchased by an ERISA plan or plan sponsor, these products are the means for funding and delivering benefits to plan beneficiaries.

A given MCO may package and market a variety of managed care products (whose features often include covered services, designated providers and compensation for those providers) which are purchased and utilized by ERISA plans and others alike to provide benefits. Managed care products may be purchased by individuals or entities wholly apart from any employment relationship governed by ERISA. These products may have more "insurance-like" characteristics, or they may simply be rented access to some network of physicians or health care professionals. An ERISA plan itself may switch from one MCO product to another, or it can choose to provide benefits using different means. Or, the employer may elect to self-fund for one group of employees at one location but provide HMO coverage for another group of employees in a different location. The MCO products purchased by the ERISA plan may vary, but the ERISA plan remains the same unless formally amended in the manner specified by the plan.[7]

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7. The Court has said that "the agreement between an HMO and an employer who pays the premiums may . . . provide elements of a plan by setting out rules under which beneficiaries will be entitled to care." *Pegram*, 530 U.S. at 223. That is so, however, only where the ERISA plan adopts as plan terms the provisions of an HMO

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ERISA's regulatory domain includes more than the ERISA plan itself. ERISA also regulates the relationships between plans and other specified entities and individuals. Principally, these other entities and individuals are the "employer" or "plan sponsor," 29 U.S.C. § 1002(5), § 1002(16)(B), the plan "participant" or "beneficiary," 29 U.S.C. §§ 1002(7) and (8), the plan "administrator," 29 U.S.C. § 1002(16)(A), and plan "fiduciar[ies]." 29 U.S.C. § 1002(21)(A). Some courts have called employers, plan administrators, fiduciaries, participants, and beneficiaries "traditional ERISA entities." *See, e.g., Bullock v. Equitable Life Assur. Soc. of U.S.*, 259 F.3d 395, 399 (5th Cir. 2001).

ERISA imposes comprehensive decision-making duties on plan fiduciaries, 29 U.S.C. § 1104, imposes liability to the plan for a breach of those duties, *id.*, §§ 1105, 1109, and prohibits certain transactions between a plan and a plan fiduciary. *Id.*, § 1106(b). ERISA imposes obligations on the employer or plan sponsor to fund the plan and maintain records, *id.*, §§ 1059, 1082, 1083, prohibits the employer from using plan assets for its own benefit, *id.*, § 1103(c), and restricts the plan's ability to purchase the employer's securities. *Id.*, § 1107. The plan administrator, who may or may not be the plan sponsor, has a number of disclosure obligations, including the duty to file annual and other reports on behalf of the plan, *id.*, §§ 1021, 1023-24, as well as notices of significant reductions in benefit accruals. *Id.*, § 1054(h).

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product. Moreover, the terms of the HMO product that is available for purchase by an ERISA plan (or by any other person or entity) are those permitted by applicable state laws regulating insurance. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739-47 (1985) (ERISA does not preempt state insurance laws that regulate the terms of insurance policies which may be sold to ERISA plans); *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, 376 (1999) ("insurers . . . [may not] displace any state regulation simply by inserting a contrary term in plan documents").

With regard to plan participants and beneficiaries, ERISA prescribes the plan's obligations to participants for the accrual and payment of plan benefits, *id.*, §§ 1054, 1056, creates a private right of action against the plan, *id.*, § 1132(a), and provides a participant with a right to a notice of denial of claim for benefits under the plan. *Id.*, § 1133.

To a much lesser extent, ERISA also addresses the relationship between plans and insurance companies. ERISA acknowledges that plans may provide welfare benefits to plan participants "through the purchase of insurance or otherwise." *Id.*, § 1002(1). ERISA obligates an insurance company that provides benefits under a plan or holds plan assets to provide certain information to the plan administrator for use in the plan's annual report. *Id.*, § 1023(a)(2)(A). The statute also establishes requirements for ensuring the adequacy of an insurer's assets when an insurance policy has been purchased for the benefit of participants in an employee pension benefit plan. *Id.*, §§ 1101(b), (c). And, in the context of group health plans, the Health Insurance Portability and Accountability Act of 1996, *id.*, §§ 1181-1191c, imposes various requirements on both health insurers and such plans with regard to disclosure, portability and limitation of any preexisting condition exclusions. *See also* 29 C.F.R. § 2520.102-3(q).

However, unlike the "traditional ERISA entities" such as beneficiaries, employers, and fiduciaries, ERISA does not presume that a relationship between an employee benefit plan and an insurer necessarily exists. Moreover, where a relationship between an insurer and a plan does exist, ERISA does not comprehensively regulate the relationship. Rather, ERISA cedes to the states via the insurance savings provision almost all the regulation of the insurer-employee benefit plan relationship. 29 U.S.C. § 1144(b)(2)(A).

C. Properly construed, the scope of "relate to" field preemption under ERISA § 514(a) is congruent with ERISA's domain.

ERISA § 514(a)'s "relate to" provision should be construed to preempt a field co-extensive with ERISA's regulatory domain — that is, state laws that primarily regulate either: (1) employee benefit plans (including their establishment, content, or administration); or (2) the relationships between plans and other entities and individuals that ERISA regulates. This construction gives meaning to the statutory term "relate to," because the preempted field encompasses more than state laws that regulate the plan itself. This construction also gives meaning to ERISA § 514(a)'s preemption provision as a whole, because the result is field preemption (rather than merely conflict preemption based upon specific statutory provisions). *Cf. Dillingham*, 519 U.S. at 335-36 (Scalia, J., concurring); *Egelhoff v. Egelhoff*, 532 U.S. 141, 152-53 (2001) (Scalia, J., concurring); *id.* at 153-54 (Breyer, J., dissenting).

For example, ERISA does not require employers to have employee benefit plans, nor does the federal statute "mandate what kinds of benefits employers must provide if they choose to have [an employee benefit] plan." *Pegram*, 530 U.S. at 226-27. Nevertheless, because ERISA § 514(a) preempts the field encompassed by ERISA's regulatory domain (which begins with the employee benefit plans itself), states may not mandate the benefits that such plans must provide. *See, e.g., Dillingham*, 519 U.S. at 328. Similarly, because ERISA's domain also encompasses the relationship between the plan and plan administrator, a state law that focuses on any aspect of that relationship "relate[s] to" the plan — regardless of whether ERISA itself addresses that specific part of the relationship. *See, e.g., UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 378-79 (1999) (state law making the "policyholder-employer the agent of the insurer.").

The "relate to" preemption analysis offered by *amici* reinforces the statutory objectives as articulated in ERISA § 1001. It preserves for exclusive federal regulation those areas that ERISA does regulate, but does not threaten to create regulatory voids beyond ERISA's regulatory scope. This analysis also materially assists in clarifying — for ERISA plan designers, for state legislatures, and for lower courts — the scope of ERISA § 514(a)'s field preemption. The boundaries of the preempted field are delimited by ERISA's regulatory scope. While *amici* do not pretend that this analysis will yield easy answers for every preemption issue, they do contend that it will aim the focus of inquiry in the correct direction.

Three additional points concerning this suggested construction of ERISA § 514(a) are also pertinent. First, the analysis makes sense of the insurance savings provision of ERISA § 514(a)(2)(A), which "reclaims a substantial amount of ground" that ERISA § 514(a) preempts by saving state laws that "regulate[s] insurance." *Rush Prudential*, 122 S. Ct. at 2158. ERISA regulates the relationship between plans and insurers much less intensively than it regulates the relationship between plans and the "traditional ERISA entities," such as plan sponsors, fiduciaries and beneficiaries. ERISA's regulation also contrasts sharply with the "extensive state regulation" of insurance, including group health insurance. *See Metropolitan Life*, 471 U.S. at 728 & n.2 (identifying state laws governing solvency, the qualifications of management, claims practices, rates, mandated-benefits, grace periods, and conversion privileges as examples of categories of state laws regulating insurance). Nonetheless, ERISA does at times address insurers and insurance and their relationship with employee benefit plans. *See* Part IB, *supra*. Thus, the insurance savings provision is necessary to ensure that state insurance regulation is not caught in the field preemption of ERISA § 514(a), a result that would leave the

plan-insurer relationship largely in a regulatory void. *See FMC Corp. v. Holliday*, 498 U.S. 52, 64 (1990) ("the saving clause . . . protect[s] state insurance regulation of insurance contracts purchased by employee benefit plans.").

Second, *amici*'s proposed construction of ERISA § 514(a)'s "relate to" provision concerns only field preemption under that statutory section. It does not alter traditional conflict preemption principles. A state statute is still preempted when it prevents or frustrates the accomplishment of ERISA's objectives (or when compliance with both the state and federal regimes is impossible. *See Geier v. American Honda Motor Co.*, 529 U.S. 861, 873-74 (2000) (calling difference between types of conflict preemption only "terminological")). This Court has used traditional conflict preemption principles to decide a number of ERISA preemption cases independently of field preemption under ERISA § 514(a). *See, e.g., Boggs v. Boggs*, 520 U.S. 833, 841 (1997) ("We can begin[] and . . . end[] the analysis by simply asking if state law conflicts with the provisions of ERISA or operates to frustrate its objects."); *John Hancock Mutual Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99 (1993) ("State law governing insurance generally is not displaced, but 'where [that] law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress,' federal preemption occurs."); *Ingersoll-Rand Co. v. McClendon*, 489 U.S. 133, 142 (1990) (state cause of action conflicts with ERISA cause of action).

Third, the construction of ERISA § 514(a)'s "relate to" provision suggested here is consistent with the results (albeit not necessarily the reasoning) of most or all of the Court's preemption decisions under ERISA § 514(a). For example, state laws that regulate plan benefits or other content of ERISA plans are preempted by § 514(a), as held in cases such as *FMC Corp.*, 498 U.S. at 60 (Pennsylvania statute

preempted because it "prohibits plans from being structured in a manner requiring reimbursement in the event of recovery from a third party"); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983) (New York statutes "which prohibit[] employers from structuring their employee benefit plans in a manner that discriminates on the basis of pregnancy" and which "require[] employers to pay employees specific benefits" are preempted); and *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524-25 (1981) (New Jersey statute prohibiting set-off of workers' compensation awards allowed by ERISA, 29 U.S.C. § 1053(a), is preempted). Similarly, state laws that regulate benefits administration "relate to" an employee benefit plan under § 514(a), *see Egelhoff*, 532 U.S. at 147-48 (Washington statute "govern[ing] the payment of benefits, a central matter of plan administration" preempted because it "bind[s] ERISA plan administrators to a particular choice of rules for determining beneficiary status"), as do laws that regulate the relationship between the beneficiary and the plan, *see, e.g., UNUM*, 526 U.S. at 367 (notice-prejudice rule, which allows claim filed out of time unless delay has caused prejudice, "relate[s] to" plan).[8]

At the same time, statutes that regulate relationships between ERISA plans and parties not regulated by ERISA fall outside the scope of ERISA field preemption under *amici*'s proposed construction of § 514(a). *See, e.g., Mackey*, 486 U.S. at 833 ("lawsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan" are not preempted). Likewise, laws of general application that do not regulate employee benefit plans but may have some economic or other "effect" on them are not within the field preempted by § 514(a). *See Travelers*, 514 U.S. at 659;

8. In *UNUM*, the state law was nevertheless saved from preemption by ERISA § 514(b)(2)(A)'s savings provision for state insurance laws.

Dillingham, 519 U.S. at 334; *De Buono*, 520 U.S. at 815-16. Areas of state law, such as medical decisionmaking, are even further afield from ERISA's regulatory domain. *Cf. Pegram*, 530 U.S. at 236-37 (mixed eligibility and medical treatment decisions are not within ERISA's regulatory domain).[9]

In sum, focusing the ERISA § 514(a) analysis on whether the state law primarily regulates the establishment, content or administration of an employee benefit plan or its relationships with other ERISA-regulated entities gives meaningful content to § 514(a). It also defines the scope of ERISA field preemption in ways that make sense in terms of the Act viewed as a whole, while leaving States able to regulate within their traditional "separate sphere[] of governmental authority." *Fort Halifax*, 482 U.S. at 19. By more clearly defining what lies within the field preempted

9. *Amici*'s proposed construction of § 514(a) is difficult to reconcile with the part of the opinion in *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988), which ruled that Georgia's antigarnishment statute "relate[s] to" employee benefit plans (and therefore falls within the preempted field) merely because it "refers to" such plans. *Id.* at 829-30. On the other hand, a benefit of *amici*'s analysis is that it provides a more substantive rule of decision (and one that is more consonant with ERISA's objectives) than simply whether or not a state statute *mentions* ERISA plans. *See, e.g., Prudential Ins. Co. v. National Park Medical Ctr., Inc.*, 154 F.3d 812, 823-24 (8th Cir. 1998) (Arkansas Any Willing Provider statute held preempted because it *exempted* self-funded plans from its requirements); *Kentucky Ass'n of Health Plans v. Nichols*, 227 F.3d 352, 360 (6th Cir. 2000) (same "relate to" reasoning by court below). (Even under *Mackey*'s "reference to" analysis, the result in *National Park Medical Ctr.*, makes no sense. That case held that the Any Willing Provider statute "relate[d] to" ERISA plans based solely on a statutory provision exempting such plans from coverage. But the court then held the entire statute preempted — whereas ERISA § 514(a) plainly states that state laws are preempted only "*insofar as*" they relate to employee benefit plans. 29 U.S.C. § 1144(a) (emphasis added)).

by § 514(a)'s "relate to" provision, the areas of state law that lie outside the preempted field, such as health care and the practice of medicine, can be more easily determined. The approach also makes sense of the insurance savings provision, leaves conflict preemption under ERISA unaffected, and is generally consistent with the results in the Court's previous § 514(a) preemption cases.

D. State laws like the Kentucky statute, which regulate health care, are not within ERISA's domain and therefore are not within the field preempted by ERISA § 514(a).

The Kentucky AWP statute is not preempted by ERISA § 514(a) under the construction advocated by *amici*. First, the AWP statute does not regulate employee benefit plans. As discussed in Part IB, *supra*, the product offered for sale by an MCO (or other insurer) is not the ERISA plan. The record in this case also confirms that conclusion. The exemplar "Certificate of Coverage," *see* Joint App. 21a, is not an ERISA plan. The exemplar itself distinguishes between the "Certificate" and the "Group Plan" in its Definitions section, Joint App. 24a, 26a, making clear that the ERISA plan is a written instrument apart from the Certificate of Coverage. In addition, the Certificate of Coverage does not even conform to the Department of Labor's requirements for an SPD. *See* 29 C.F.R. § 2520.102-3 (listing required contents of SPD).[10]

10. For example, the Certificate of Coverage does not identify the employer identification number (EIN) assigned to the plan sponsor, 29 C.F.R. § 2520.102-3(c), the type of administration of the plan, *id.*, § 2520.102-3(e), the name, address and telephone number of the plan administrator, *id.*, § 2520.102-3(f), and the designated agent for service of process, *id.*, § 2520.102-3(g).

Second, the Kentucky AWP statute regulates the relationship between the MCO (insurer) and health care service provider and operates independently of any connection to an ERISA plan. Petitioners and their *amici* repeatedly make this point. *See, e.g.*, Pet. Brief at 11 ("AWP laws . . . regulate non-insurance contracts between non-insurers and insurers."); *id.* at 28 (contracts governed by these statutes are "between insurers and third-party providers — pharmacies, doctors, hospitals, and so on."); Community Health Partners *Amicus* Brief at 11 ("The form of AWP statutes relates not to the insurer-insured relationship, but instead to the insurer-provider relationship."). The relationship between insurer and service provider is not a relationship regulated by ERISA. For this reason as well, the Kentucky statute does not "relate to" employee benefit plans under ERISA § 514(a).[11]

11. As discussed in Part IA, *supra*, this particular type of state statute also should not be preempted under the Court's current "relate to" analysis. First, the state statute regulates health care, a type of regulation which the Court has repeatedly indicated is not within the field preempted by ERISA § 514(a). Second, Petitioners' argument is that the statute "relate[s] to" ERISA plans because it "'bear[s] indirectly but substantially on all insured benefits plans' by precluding them from purchasing medical coverage from HMOs with limited provider networks." Pet. Brief at 12. This argument is analytically identical to the failed argument in *Travelers* that the "indirect economic effect" of the surcharge on hospital bills for commercial insurers "related to" employee benefit plans because it prevented those plans from purchasing medical coverage from commercial insurers without being subject to the surcharge. *Travelers*, 514 U.S. at 659. Like that state regulation in *Travelers*, Petitioners argue the AWP statute "drive[s] up the cost of the health care services managed by HMOs," Pet. Brief at 5, and those costs may be passed on to ERISA-governed employee benefit plans. Moreover, the AWP statute's alleged effect on ERISA plans is even more attenuated than the "direct impact" of the hospital revenue tax in *De Buono*, where the ERISA fund argued that the tax, in essence, prevented the fund's

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This conclusion that a statute governing the relationship between a physician and an insurer does not "relate to" employee benefit plans is also supported by several lower court decisions. Courts have almost uniformly held that ERISA does not preempt state law misrepresentation claims by a physician against an MCO arising from the MCO's wrongful failure to pay promised benefits to the physician, because such a claim does not "relate to" an employee benefit plan. "State law claims brought by health care providers against plan insurers too tenuously affect ERISA plans to be preempted by the Act." *Lordmann Enterp., Inc. v. Equicor, Inc.*, 32 F.3d 1529, 1533 (11th Cir. 1994).[12] *See also Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039, 1045 (9th Cir. 1998) (AWP statute "is merely one of many state laws that regulates one of many products that an employee benefit plan might choose to buy" and so does not "relate to" ERISA plan).

Under the reasoning of the court below, the Kentucky statute could be viewed as also regulating the relationship

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hospital from obtaining as much revenue as it would without the imposition of the tax. Despite the direct impact in *De Buono*, this Court held that the tax statute did not "relate to" an ERISA plan. 520 U.S. at 815-16; *see also Travelers*, 514 U.S. at 662 ("cost uniformity was almost certainly not an object of pre-emption"); *Dillingham*, 519 U.S. at 334 (rejecting preemption challenge to state law that "altered the incentives, but [did] not dictate the choices, facing ERISA plans").

12. *Accord Cypress Fairbanks Medical Center Inc. v. Pan-American Life Ins. Co.*, 110 F.3d 280 (5th Cir. 1997); *In Home Health, Inc. v. Prudential Ins. Co. of America*, 101 F.3d 600, 605-06 (8th Cir. 1996); *Hospice of Metro Denver, Inc. v. Group Health Ins. of Oklahoma, Inc.*, 944 F.2d 752, 756 (10th Cir. 1991); *Reichmister v. United Healthcare of the Mid-Atlantic, Inc.*, 93 F. Supp. 2d 618 (D. Md. 2000); *National Rehabilitation Hosp. v. Manpower Int'l, Inc.*, 3 F. Supp. 2d 1457, 1460 (D.D.C. 1998).

between the insurer and the employee benefit plan. That is, in the Sixth Circuit's view, the Kentucky statute increases the universe of the health care providers that are available to the plan's participants and beneficiaries, and the court saw this effect as a benefit coverage requirement. Under the construction of § 514(a) proposed by *amici*, there is no need to address that issue. The Kentucky statute directly and primarily regulates the relationship between the insurer and the health care service provider. The statute therefore does not relate to employee benefit plans, and so is not within the field preempted by ERISA § 514(a). It is, however, also true that if (or to any extent that) the Kentucky statute were deemed to regulate insurance policy benefits, it would by definition be a state law regulating insurance. The statute therefore would necessarily be saved from field preemption by ERISA § 514(b)(2)(A)'s savings provision for state laws that regulate insurance.

II. THE KENTUCKY STATUTE ALSO "REGULATES INSURANCE" WITHIN THE MEANING OF ERISA § 514(b)(2)(A).

The Kentucky statute also is saved from preemption because it "regulates insurance." 29 U.S.C. § 1144(b)(2)(A). This Court has taken pains recently not to "plot the exact perimeter of the savings clause." *Rush Prudential*, 122 S. Ct. at 2159. Instead, this Court has described its savings provision analysis as "supple" and stressed that the three McCarran-Ferguson factors it often references are simply relevant "guideposts, not separate essential elements . . . that must each be satisfied" for a state law to be saved. *UNUM*, 526 U.S. at 374. "[A]s long as providing insurance fairly accounts for the application of state law, the saving clause may apply." *Rush Prudential*, 122 S. Ct. at 2160.

Amici suggest that the Court's decisions in *Department of Treasury v. Fabe*, 508 U.S. 491 (1993) and *Barnett Bank v. Nelson*, 517 U.S. 25 (1996), demonstrate that, outside the

antitrust context, strict adherence to the three factors set forth in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982) may lead to an overly narrow view of laws which "regulate insurance" within the meaning of the McCarran-Ferguson Act. 15 U.S.C. § 1012. The Court in *Fabe* stated that "the primary purpose of the insurance company" is "the payment of claims made against policies." *Fabe*, 508 U.S. at 506. A statute which "serve[s] to ensure that, if possible, policyholders ultimately will receive payment on their claims" is one that has been "enacted for the purpose of regulating the business of insurance." *Id.* This Court in *Rush Prudential* acknowledged that the insurance savings provision in ERISA § 514(b)(2)(A) has a similar breadth. 122 S. Ct. at 2160 ("as long as providing insurance fairly accounts for the application of state law, the savings clause may apply.")

In early ERISA insurance savings provision cases, this Court incorporated the part of the analysis of the McCarran-Ferguson Act that addressed exemption from antitrust liability. *Metropolitan Life*, 471 U.S. at 742-43 (relying on *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979) and *Pireno*). More recently, however, the Court acknowledged that the two clauses in Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b), have different scopes. "[T]he first clause of § 2(b) was intended to further Congress' primary objective of granting the states broad regulatory authority over the business of insurance. The second clause accomplishes Congress' secondary goal, which was to carve out only a narrow exemption for 'the business of insurance' from the federal antitrust laws." *Fabe*, 508 U.S. at 505 (citing *Royal Drug*, 440 U.S. at 218 n.18). This Court has stated that the first clause is "not so narrowly circumscribed" as the second clause dealing with antitrust liability. *Id.* at 504. When interpreting the first clause of Section 2(b), state laws that "possess the 'end, intention, or aim' of adjusting, managing, or controlling the business of insurance" also fall within the category of laws that regulate the business of insurance. *Id.* at 505.

It would be a mistake, therefore, to rely exclusively on cases construing the McCarran-Ferguson Act in the context of potential exemption from antitrust liability, such as *Royal Drug* and *Pireno*, when determining the perimeter of what constitutes a regulation of the business of insurance. *Id.* at 505. Under *Fabe*'s broader analysis, "state laws enacted 'for the purpose of regulating the business of insurance' do not yield to conflicting federal statutes unless a federal statute specifically requires otherwise." *Id.* at 507. Because Kentucky's AWP statute "adjust[s], manag[es], or control[s] the business of insurance," *id.* at 505, by regulating an HMO (or other "health insurer")'s ability to contract (or not contract) with a physician or health care provider, it is a law enacted for the purpose of regulating the business of insurance. The statute also, at least indirectly, has the potential to alter the composition of physicians a health insurer must include in its network. Under *Fabe*, the McCarran-Ferguson Act would dictate that the Kentucky statute is not preempted because ERISA does not "specifically require[]" preemption. *Id.* at 507.

In *Barnett Bank*, the Court construed the "business of insurance" from a different perspective. There, the Court focused on the exception to the McCarran-Ferguson Act's anti-preemption rule that applies when Congress has enacted a federal statute that "specifically relates to the business of insurance." 15 U.S.C. § 1012(b). The federal statute in question, 12 U.S.C. § 92, allows national banks under certain circumstances to sell insurance as agents on behalf of insurance companies. *Barnett Bank*, 517 U.S. at 28. Despite the fact that a Florida statute prohibited national banks from selling insurance in Florida, *id.* at 29, the Court held that the federal statute applied because it regulates the "business of insurance." *Id.* at 39. While the Court said that the federal statute "affect[ed] the relation of insured to insurer and the spreading of risk," *id.*, it made no mention of the third factor in the *Pireno* test — limitation of the practice to entities within the insurance industry. Moreover, the Court focused on the statute's emphasis on "industry-specific selling

practices," such as the solicitation and sale of insurance, collection of premiums and receipt of commissions, as the basis for its determination that the statute related to "the business of insurance." *Id. Barnett Bank* indicates that "the business of insurance" according to the McCarran-Ferguson Act includes the business practices of insurance agents, not simply insurers, and does not focus exclusively on the spreading of risk between insurer and insured. In fact, since the insurer, not the insurance agent, presumably accepts the risk from the insured, it seems that 12 U.S.C. § 92 spreads risk at most in nominal terms. Kentucky's AWP statute provides for risk-spreading at least as much as 12 U.S.C. § 92 because it shifts the increased cost associated with an insured obtaining medical services from a physician outside the HMO's limited provider network from the insured to the HMO. According to *Barnett Bank*, this is sufficient to conclude that the AWP statute regulates the "business of insurance."

Under the broader analysis set forth in *Fabe* and *Barnett Bank*, as well as for the reasons set forth in the Solicitor General's *amicus* brief and Respondent's brief, the Kentucky statute "regulates insurance" and is saved from preemption.

CONCLUSION

Refocusing the ERISA § 514(a) preemption analysis on the "employee benefit plan" and the plan's relationships with other ERISA-regulated entities will provide the Court with a more useful method of analysis than the current "relate to" preemption analysis. *Amici*'s proposed analysis adheres to the statutory text as well as the objectives of both ERISA's substantive provisions and its preemption provisions. It also harmonizes the holdings of almost all of the Court's prior ERISA § 514(a) precedents. Employing *amici*'s suggested analysis in this case, Kentucky's AWP statute clearly is outside the field preempted by ERISA § 514(a).

For all of the foregoing reasons, the judgment below should be affirmed.

Respectfully submitted,

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